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CHALENG 2005 Survey: VA Central Alabama HCS (VAMC Montgomery - 619 and VAMC Tuskegee - 619A4)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 375

2. Estimated Number of Veterans who are Chronically Homeless: 128

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 375 (estimated number of homeless veterans in service area) **x chronically homeless rate (34 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	242	6
Transitional Housing Beds	112	35
Permanent Housing Beds	10	80

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

VA disablity/pension	Maintain ongoing communication and involvement with Regional Office Homeless coordinator. Identify cases and refer.
Immediate shelter	Provide case management to veterans utilizing community shelters. Identify additional emergency shelters and support providers.
Long-term, permanent housing	Educate veterans about community resources and their benefits. Coach veterans on how to advocate for their needs.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **62 Non-VA staff Participants: 25.9%**
Homeless/Formerly Homeless: **66.1%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	4.10	2.0%	3.47
Food	4.10	2.0%	3.80
Clothing	3.66	7.0%	3.61
Emergency (immediate) shelter	3.73	30.0%	3.33
Halfway house or transitional living facility	3.34	16.0%	3.07
Long-term, permanent housing	3.02	29.0%	2.49
Detoxification from substances	3.80	9.0%	3.41
Treatment for substance abuse	4.17	18.0%	3.55
Services for emotional or psychiatric problems	3.8	24.0%	3.46
Treatment for dual diagnosis	3.8	7.0%	3.30
Family counseling	3.25	7.0%	2.99
Medical services	4.02	11.0%	3.78
Women's health care	3.43	2.0%	3.23
Help with medication	4.17	4.0%	3.46
Drop-in center or day program	3.58	.0%	2.98
AIDS/HIV testing/counseling	3.85	.0%	3.51
TB testing	4.33	.0%	3.71
TB treatment	4.08	.0%	3.57
Hepatitis C testing	4.22	2.0%	3.63
Dental care	3.47	18.0%	2.59
Eye care	3.66	4.0%	2.88
Glasses	3.60	2.0%	2.88
VA disability/pension	3.25	34.0%	3.40
Welfare payments	3.06	.0%	3.03
SSI/SSD process	3.19	11.0%	3.10
Guardianship (financial)	3.31	.0%	2.85
Help managing money	3.84	4.0%	2.87
Job training	3.70	15.0%	3.02
Help with finding a job or getting employment	3.60	17.0%	3.14
Help getting needed documents or identification	3.61	2.0%	3.28
Help with transportation	3.67	9.0%	3.02
Education	3.40	7.0%	3.00
Child care	2.96	2.0%	2.45
Legal assistance	3.07	4.0%	2.71
Discharge upgrade	3.37	2.0%	3.00
Spiritual	4.16	4.0%	3.36
Re-entry services for incarcerated veterans	3.24	11.0%	2.72
Elder Healthcare	3.75	2.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.20
Co-location of Services - Services from the VA and your agency provided in one location.	2.67
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.93
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	3.07
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	3.00
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.60
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.60
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	3.07
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	3.13
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.73
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.87
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.87

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	4.07
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	4.53

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CHALENG 2005 Survey: VAMC - Augusta, GA - 509

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 2809

2. Estimated Number of Veterans who are Chronically Homeless: 478

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 2809 (estimated number of homeless veterans in service area) **x chronically homeless rate (17 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	237	178
Transitional Housing Beds	237	210
Permanent Housing Beds	0	50

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 15

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	Encourage VA Grant and Per Diem applications from local agencies. Support St. Vincent De Paul Medical Clinic with its proposal to create 5-8 transitional beds for recently hospitalized homeless persons.
Long-term, permanent housing	Encourage and endorse development of long-term housing. Participate in Mayor's Task Force on Homelessness.
Job training	Promote employment/training in collaboration with Goodwill Industries, Department of Labor, and Disabled Veterans Outreach Program (DVOP). Support Salvation Army's funding request to provide job training for homeless veterans.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **40** **Non-VA staff Participants: 76.9%**
Homeless/Formerly Homeless: **5.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.24	6.0%	3.47
Food	3.63	15.0%	3.80
Clothing	3.51	9.0%	3.61
Emergency (immediate) shelter	2.95	18.0%	3.33
Halfway house or transitional living facility	2.74	30.0%	3.07
Long-term, permanent housing	2.19	24.0%	2.49
Detoxification from substances	3.11	18.0%	3.41
Treatment for substance abuse	3.11	9.0%	3.55
Services for emotional or psychiatric problems	3.2	6.0%	3.46
Treatment for dual diagnosis	3.1	6.0%	3.30
Family counseling	2.79	3.0%	2.99
Medical services	3.45	18.0%	3.78
Women's health care	3.03	3.0%	3.23
Help with medication	3.03	6.0%	3.46
Drop-in center or day program	3.00	6.0%	2.98
AIDS/HIV testing/counseling	3.37	.0%	3.51
TB testing	3.55	.0%	3.71
TB treatment	3.50	.0%	3.57
Hepatitis C testing	3.42	.0%	3.63
Dental care	2.62	15.0%	2.59
Eye care	2.74	3.0%	2.88
Glasses	2.86	3.0%	2.88
VA disability/pension	3.22	3.0%	3.40
Welfare payments	2.76	.0%	3.03
SSI/SSD process	3.00	3.0%	3.10
Guardianship (financial)	2.77	.0%	2.85
Help managing money	2.63	9.0%	2.87
Job training	2.86	15.0%	3.02
Help with finding a job or getting employment	2.94	24.0%	3.14
Help getting needed documents or identification	3.06	.0%	3.28
Help with transportation	2.89	12.0%	3.02
Education	2.80	3.0%	3.00
Child care	2.46	3.0%	2.45
Legal assistance	2.51	3.0%	2.71
Discharge upgrade	2.73	.0%	3.00
Spiritual	3.22	3.0%	3.36
Re-entry services for incarcerated veterans	2.25	21.0%	2.72
Elder Healthcare	2.62	12.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	1.75
Co-location of Services - Services from the VA and your agency provided in one location.	1.46
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.42
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	1.54
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.58
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.17
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.25
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.54
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.33
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.21
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.33
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.46

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.04
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	2.96

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CHALENG 2005 Survey: VAMC Atlanta, GA - 508 (Decatur, GA)

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 2106

2. Estimated Number of Veterans who are Chronically Homeless: 674

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 2106 (estimated number of homeless veterans in service area) **x chronically homeless rate (32 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	503	129
Transitional Housing Beds	464	0
Permanent Housing Beds	146	130

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 3

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Complete inspection of homeless facility that will assist at least 46 veterans. Continue to promote interest in potential GPD providers application process via aggressive outreach efforts.
Transitional living facility or halfway house	Complete inspection of homeless facility that will assist at least 46 veterans. Continue to promote interest in potential GPD providers application process via aggressive outreach efforts.
Long-term, permanent housing	Complete inspection of homeless facility that will assist at least 46 veterans. Continue to promote interest in potential GPD providers application process via aggressive outreach efforts.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **42 Non-VA staff Participants: 50.0%**
Homeless/Formerly Homeless: **7.1%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.47	3.0%	3.47
Food	3.58	15.0%	3.80
Clothing	3.51	3.0%	3.61
Emergency (immediate) shelter	3.18	21.0%	3.33
Halfway house or transitional living facility	3.27	32.0%	3.07
Long-term, permanent housing	2.78	29.0%	2.49
Detoxification from substances	3.03	9.0%	3.41
Treatment for substance abuse	3.63	18.0%	3.55
Services for emotional or psychiatric problems	3.2	15.0%	3.46
Treatment for dual diagnosis	3.2	12.0%	3.30
Family counseling	2.72	.0%	2.99
Medical services	3.50	3.0%	3.78
Women's health care	3.42	15.0%	3.23
Help with medication	3.33	.0%	3.46
Drop-in center or day program	2.81	3.0%	2.98
AIDS/HIV testing/counseling	3.84	.0%	3.51
TB testing	3.97	.0%	3.71
TB treatment	3.92	.0%	3.57
Hepatitis C testing	3.81	.0%	3.63
Dental care	3.03	9.0%	2.59
Eye care	3.05	6.0%	2.88
Glasses	3.16	.0%	2.88
VA disability/pension	3.27	3.0%	3.40
Welfare payments	3.19	.0%	3.03
SSI/SSD process	2.97	12.0%	3.10
Guardianship (financial)	2.70	.0%	2.85
Help managing money	2.89	6.0%	2.87
Job training	2.97	21.0%	3.02
Help with finding a job or getting employment	3.11	15.0%	3.14
Help getting needed documents or identification	3.22	3.0%	3.28
Help with transportation	2.84	15.0%	3.02
Education	2.95	6.0%	3.00
Child care	2.50	3.0%	2.45
Legal assistance	2.89	.0%	2.71
Discharge upgrade	3.00	.0%	3.00
Spiritual	3.53	3.0%	3.36
Re-entry services for incarcerated veterans	2.94	15.0%	2.72
Elder Healthcare	3.00	6.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.19
Co-location of Services - Services from the VA and your agency provided in one location.	1.73
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.73
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.38
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.63
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.00
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.81
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.00
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.06
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.88
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.88
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.13

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.44
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.88

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CHALENG 2005 Survey: VAMC Birmingham, AL - 521

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 410

2. Estimated Number of Veterans who are Chronically Homeless: 180

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 410 (estimated number of homeless veterans in service area) **x chronically homeless rate (44 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	65	15
Transitional Housing Beds	57	10
Permanent Housing Beds	60	20

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Transitional living facility or halfway house	We plan to continue to request funds from the medical center and VISN for contract halfway housing.
Treatment for dual diagnosis	Dual diagnosis is a major service gap. We are looking to identify a halfway house, approximately 10 units, that would be willing to collaborate on a dual diagnosis program.
Dental care	We need to secure funding for dental assistance. We were funded in FY 2002 for dental but this money has all been used.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **13** **Non-VA staff Participants: 100.0%**
Homeless/Formerly Homeless: **15.4%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	2.91	.0%	3.47
Food	3.67	.0%	3.80
Clothing	3.33	.0%	3.61
Emergency (immediate) shelter	2.27	18.0%	3.33
Halfway house or transitional living facility	2.08	36.0%	3.07
Long-term, permanent housing	2.31	58.0%	2.49
Detoxification from substances	2.55	18.0%	3.41
Treatment for substance abuse	2.62	27.0%	3.55
Services for emotional or psychiatric problems	2.6	8.0%	3.46
Treatment for dual diagnosis	2.4	9.0%	3.30
Family counseling	2.64	9.0%	2.99
Medical services	3.33	.0%	3.78
Women's health care	2.67	18.0%	3.23
Help with medication	2.58	9.0%	3.46
Drop-in center or day program	2.64	.0%	2.98
AIDS/HIV testing/counseling	2.83	.0%	3.51
TB testing	2.75	.0%	3.71
TB treatment	2.67	.0%	3.57
Hepatitis C testing	2.64	.0%	3.63
Dental care	2.50	.0%	2.59
Eye care	2.67	.0%	2.88
Glasses	2.67	.0%	2.88
VA disability/pension	2.70	18.0%	3.40
Welfare payments	2.89	18.0%	3.03
SSI/SSD process	2.45	9.0%	3.10
Guardianship (financial)	2.20	.0%	2.85
Help managing money	2.36	9.0%	2.87
Job training	2.36	9.0%	3.02
Help with finding a job or getting employment	2.58	25.0%	3.14
Help getting needed documents or identification	2.36	.0%	3.28
Help with transportation	2.00	9.0%	3.02
Education	2.40	.0%	3.00
Child care	2.20	.0%	2.45
Legal assistance	2.22	.0%	2.71
Discharge upgrade	2.13	.0%	3.00
Spiritual	2.90	.0%	3.36
Re-entry services for incarcerated veterans	1.82	9.0%	2.72
Elder Healthcare	2.50	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.38
Co-location of Services - Services from the VA and your agency provided in one location.	1.62
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.69
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.38
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.77
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.54
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.50
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.92
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.46
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.38
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.46
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.08

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.08
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.17

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Charleston, SC - 534

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 375

2. Estimated Number of Veterans who are Chronically Homeless: 101

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 375 (estimated number of homeless veterans in service area) **x chronically homeless rate (27 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	233	189
Transitional Housing Beds	160	160
Permanent Housing Beds	105	75

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 5

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	Continue to refer veterans to Humanities Foundation. Work within the Continuum of Care to support grant proposals to fund affordable permanent housing.
Dental care	Work with Continuum of Care to identify and expand potential resources to provide dental care. Participate in annually Convoy of Hope to offer dental services to veterans and their families.
Other	Increase frequency of CHALENG meetings and focus upon an updated community resource guide for veterans.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **17** **Non-VA staff Participants: 93.8%**
Homeless/Formerly Homeless: **5.9%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.08	.0%	3.47
Food	3.50	.0%	3.80
Clothing	3.36	.0%	3.61
Emergency (immediate) shelter	2.67	17.0%	3.33
Halfway house or transitional living facility	2.85	17.0%	3.07
Long-term, permanent housing	2.00	33.0%	2.49
Detoxification from substances	3.00	8.0%	3.41
Treatment for substance abuse	3.17	25.0%	3.55
Services for emotional or psychiatric problems	3.0	17.0%	3.46
Treatment for dual diagnosis	3.2	.0%	3.30
Family counseling	2.83	.0%	2.99
Medical services	3.25	.0%	3.78
Women's health care	2.75	8.0%	3.23
Help with medication	3.23	17.0%	3.46
Drop-in center or day program	1.92	.0%	2.98
AIDS/HIV testing/counseling	2.73	.0%	3.51
TB testing	3.27	.0%	3.71
TB treatment	3.36	.0%	3.57
Hepatitis C testing	3.09	.0%	3.63
Dental care	1.92	17.0%	2.59
Eye care	2.25	8.0%	2.88
Glasses	2.17	.0%	2.88
VA disability/pension	3.33	17.0%	3.40
Welfare payments	2.50	.0%	3.03
SSI/SSD process	2.91	.0%	3.10
Guardianship (financial)	2.73	.0%	2.85
Help managing money	2.55	17.0%	2.87
Job training	2.73	17.0%	3.02
Help with finding a job or getting employment	2.92	17.0%	3.14
Help getting needed documents or identification	3.00	.0%	3.28
Help with transportation	2.38	42.0%	3.02
Education	2.55	.0%	3.00
Child care	1.80	17.0%	2.45
Legal assistance	2.00	.0%	2.71
Discharge upgrade	3.00	.0%	3.00
Spiritual	2.73	8.0%	3.36
Re-entry services for incarcerated veterans	2.27	.0%	2.72
Elder Healthcare	2.36	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.70
Co-location of Services - Services from the VA and your agency provided in one location.	1.91
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	1.40
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.30
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.55
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.70
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.90
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.56
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.40
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.60
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.50
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.60

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.38
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.46

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Columbia, SC - 544

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 1000

2. Estimated Number of Veterans who are Chronically Homeless: 460

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 1000 (estimated number of homeless veterans in service area) **x chronically homeless rate (46 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	300	16
Transitional Housing Beds	30	8
Permanent Housing Beds	5	20

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Working on collaborative proposal for "Housing First" beds and services.
Transitional living facility or halfway house	Contract with Salvation Army to provide contract beds for female veterans.
Help finding a job or getting employment	Establishing Supported Employment program for seriously mentally ill veterans. Developing proposal for Critical Time Intervention Program.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **70** **Non-VA staff Participants: 81.8%**
Homeless/Formerly Homeless: **22.9%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.36	4.0%	3.47
Food	3.67	9.0%	3.80
Clothing	3.57	9.0%	3.61
Emergency (immediate) shelter	3.31	33.0%	3.33
Halfway house or transitional living facility	3.09	21.0%	3.07
Long-term, permanent housing	2.69	37.0%	2.49
Detoxification from substances	3.25	4.0%	3.41
Treatment for substance abuse	3.42	5.0%	3.55
Services for emotional or psychiatric problems	3.4	14.0%	3.46
Treatment for dual diagnosis	3.3	5.0%	3.30
Family counseling	3.20	2.0%	2.99
Medical services	3.68	14.0%	3.78
Women's health care	3.09	9.0%	3.23
Help with medication	3.48	7.0%	3.46
Drop-in center or day program	2.70	.0%	2.98
AIDS/HIV testing/counseling	3.28	4.0%	3.51
TB testing	3.52	.0%	3.71
TB treatment	3.46	.0%	3.57
Hepatitis C testing	3.35	2.0%	3.63
Dental care	2.98	16.0%	2.59
Eye care	2.94	13.0%	2.88
Glasses	3.00	7.0%	2.88
VA disability/pension	3.31	16.0%	3.40
Welfare payments	2.97	4.0%	3.03
SSI/SSD process	3.02	.0%	3.10
Guardianship (financial)	2.97	.0%	2.85
Help managing money	3.03	.0%	2.87
Job training	3.14	16.0%	3.02
Help with finding a job or getting employment	3.41	23.0%	3.14
Help getting needed documents or identification	3.42	4.0%	3.28
Help with transportation	3.30	7.0%	3.02
Education	3.10	13.0%	3.00
Child care	2.45	.0%	2.45
Legal assistance	2.81	2.0%	2.71
Discharge upgrade	3.07	9.0%	3.00
Spiritual	3.39	4.0%	3.36
Re-entry services for incarcerated veterans	2.89	7.0%	2.72
Elder Healthcare	3.23	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	3.02
Co-location of Services - Services from the VA and your agency provided in one location.	2.30
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.60
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.80
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	2.29
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	2.07
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	2.39
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.64
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	2.62
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	2.23
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	2.16
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	2.24

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.75
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.92

Prepared by John Nakashima, Ph.D., MSW
Program Analyst, Community Care, VA Greater Los Angeles HCS

CHALENG 2005 Survey: VAMC Dublin, GA - 557

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 800

2. Estimated Number of Veterans who are Chronically Homeless: (Data not available)

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 800 (estimated number of homeless veterans in service area) **x** **chronically homeless rate** (Data not available) (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	350	300
Transitional Housing Beds	0	25
Permanent Housing Beds	0	0

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Immediate shelter	Continue to maintain relationship with shelters in the Macon area. Identify new shelters throughout middle and south Georgia.
Help finding a job or getting employment	Increase vocational rehabilitation support for severely mentally ill population. Strengthen relationship with Department of Labor-Veterans Outreach.
Transportation	Continue to identify transportation alternatives.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **29** **Non-VA staff Participants: 96.4%**
Homeless/Formerly Homeless: **.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.12	.0%	3.47
Food	3.83	.0%	3.80
Clothing	3.79	.0%	3.61
Emergency (immediate) shelter	3.31	21.0%	3.33
Halfway house or transitional living facility	2.54	14.0%	3.07
Long-term, permanent housing	2.37	29.0%	2.49
Detoxification from substances	3.27	18.0%	3.41
Treatment for substance abuse	3.35	7.0%	3.55
Services for emotional or psychiatric problems	3.2	7.0%	3.46
Treatment for dual diagnosis	3.2	14.0%	3.30
Family counseling	2.77	.0%	2.99
Medical services	3.57	11.0%	3.78
Women's health care	3.00	.0%	3.23
Help with medication	3.16	.0%	3.46
Drop-in center or day program	2.08	7.0%	2.98
AIDS/HIV testing/counseling	3.64	.0%	3.51
TB testing	3.72	.0%	3.71
TB treatment	3.58	.0%	3.57
Hepatitis C testing	3.46	.0%	3.63
Dental care	2.89	4.0%	2.59
Eye care	2.75	7.0%	2.88
Glasses	2.65	.0%	2.88
VA disability/pension	2.93	14.0%	3.40
Welfare payments	2.68	11.0%	3.03
SSI/SSD process	3.26	14.0%	3.10
Guardianship (financial)	2.35	.0%	2.85
Help managing money	2.44	11.0%	2.87
Job training	3.08	18.0%	3.02
Help with finding a job or getting employment	3.13	18.0%	3.14
Help getting needed documents or identification	3.37	11.0%	3.28
Help with transportation	2.46	14.0%	3.02
Education	2.60	4.0%	3.00
Child care	2.04	11.0%	2.45
Legal assistance	2.84	.0%	2.71
Discharge upgrade	2.48	.0%	3.00
Spiritual	2.74	7.0%	3.36
Re-entry services for incarcerated veterans	2.28	11.0%	2.72
Elder Healthcare	2.42	18.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.28
Co-location of Services - Services from the VA and your agency provided in one location.	1.84
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.00
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.08
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.96
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.62
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.79
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	2.04
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.95
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.77
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.52
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.83

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.15
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.37

Prepared by John Nakashima, Ph.D., MSW
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CHALENG 2005 Survey: VAMC Tuscaloosa, AL - 679

A. Homeless Veteran Estimates:

1. Estimated Number of Homeless Veterans (from the CHALENG Point of Contact Survey): 31

2. Estimated Number of Veterans who are Chronically Homeless: 10

The federal Interagency Council on Homelessness defines chronic homelessness as follows:

> A person experiencing chronic homelessness is defined as an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last three years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions. Federal Register Vol. 70, No. 53, March 21, 2005, page 13588; http://www.hud.gov/offices/adm/grants/nofa05/gensec.pdf)

Our figure for chronically homeless is a conservative estimate. We used the following formula to obtain this number*:

> 31 (estimated number of homeless veterans in service area) **x chronically homeless rate (31 %)** (percentage of individuals who have been homeless for a year or more or had at least four homeless episodes during the past three years AND have a mental health or substance abuse disorder).*

*Note: # of homeless veterans in the service area comes from 2005 CHALENG POC survey. "Chronically homeless rate" comes from FY 2005 homeless veteran intake data provided by the VA Northeast Program Evaluation Center. (Special thanks to Dr. Wes Kasprow, NEPEC investigator for providing this data.)

Our estimate is conservative. It DOES NOT also include veterans who may not have had a substance abuse/mental health disorder but did have a disabling medical condition (VA does record information on medical conditions but not on whether the condition is "disabling").

B. Data from the Point of Contact Survey

1. Housing Inventory

Housing Inventory	Beds	# of additional beds site could use
Emergency Beds	40	15
Transitional Housing Beds	20	10
Permanent Housing Beds	1	10

2. Number of Homeless Veteran Families (veterans with minor dependents) Served in FY 2005: 0

3. CHALENG Point of Contact Action Plan for FY 2005

Long-term, permanent housing	CHALENG group partnered with Tuscaloosa Housing Authority for a second Shelter Plus Care Grant. Grant is requesting 5 vouchers for veterans. Grant application is currently pending.
Immediate shelter	CHALENG group will continue to provided education to local officials and service providers about need for additional shelter capacity.
Transitional living facility or halfway house	VA social worker will continue to distribute information about available grant monies for transitional housing programs to area service providers.

C. Data from the CHALENG Participant Survey

Number of Participant Surveys: **49** **Non-VA staff Participants: 69.4%**
Homeless/Formerly Homeless: **2.0%**

1. Needs Ranking (1=Need Unmet .... 5= Need Met)

Need	Site Mean Score	*% want to work on this need now	VHA Mean** Score (all VA sites)
Personal hygiene	3.11	.0%	3.47
Food	3.65	18.0%	3.80
Clothing	3.45	7.0%	3.61
Emergency (immediate) shelter	3.28	21.0%	3.33
Halfway house or transitional living facility	2.84	16.0%	3.07
Long-term, permanent housing	2.50	49.0%	2.49
Detoxification from substances	3.02	9.0%	3.41
Treatment for substance abuse	3.59	16.0%	3.55
Services for emotional or psychiatric problems	3.7	21.0%	3.46
Treatment for dual diagnosis	3.4	.0%	3.30
Family counseling	2.93	9.0%	2.99
Medical services	3.67	9.0%	3.78
Women's health care	3.20	5.0%	3.23
Help with medication	3.40	2.0%	3.46
Drop-in center or day program	2.76	5.0%	2.98
AIDS/HIV testing/counseling	3.45	7.0%	3.51
TB testing	3.70	.0%	3.71
TB treatment	3.59	.0%	3.57
Hepatitis C testing	3.57	.0%	3.63
Dental care	2.77	12.0%	2.59
Eye care	2.81	7.0%	2.88
Glasses	2.83	.0%	2.88
VA disability/pension	3.34	5.0%	3.40
Welfare payments	3.00	.0%	3.03
SSI/SSD process	3.32	2.0%	3.10
Guardianship (financial)	2.87	2.0%	2.85
Help managing money	2.94	7.0%	2.87
Job training	2.98	16.0%	3.02
Help with finding a job or getting employment	2.98	12.0%	3.14
Help getting needed documents or identification	3.09	.0%	3.28
Help with transportation	2.74	9.0%	3.02
Education	2.78	7.0%	3.00
Child care	2.20	2.0%	2.45
Legal assistance	2.37	5.0%	2.71
Discharge upgrade	2.80	.0%	3.00
Spiritual	3.06	.0%	3.36
Re-entry services for incarcerated veterans	2.51	16.0%	2.72
Elder Healthcare	3.02	.0%	3.06

*** % of site participants who identified this need as one of the top three they would like to work on now.**
****VHA: Veterans Healthcare Administration (136 reporting POC sites, n=4321).**

2. Level of Collaboration Activities Between VA and Community

Implementation Scale **1 = None**, no steps taken to initiate implementation of the strategy. **2 = Low**, in planning and/or initial minor steps taken. **3 = Moderate**, significant steps taken but full implementation not achieved. **4 = High**, strategy fully implemented.	**Site Mean Score (non-VA respondents only)**
Interagency Coordinating Body - Representatives from the VA and your agency meet formally to exchange information, do needs assessment, plan formal agreements, and promote access to services.	2.48
Co-location of Services - Services from the VA and your agency provided in one location.	1.63
Cross-Training - Staff training about the objectives, procedures and services of the VA and your agency.	2.19
Interagency Agreements/ Memoranda of Understanding - Formal and informal agreements between the VA and your agency covering such areas as collaboration, referrals, sharing client information, or coordinating services.	2.03
Interagency Client Tracking Systems/ Management Information Systems - Shared computer tracking systems that link the VA and your agency to promote information sharing, referrals, and client access.	1.34
Pooled/Joint Funding - Combining or layering funds from the VA and your agency to create new resources or services.	1.59
Uniform Applications, Eligibility Criteria, and Intake Assessments – Standardized form that the client fills out only once to apply for services at the VA and your agency.	1.57
Interagency Service Delivery Team/ Provider Coalition - Service team comprised of staff from the VA and your agency to assist clients with multiple needs.	1.83
Consolidation of Programs/ Agencies - Combining programs from the VA and your agency under one administrative structure to integrate service delivery.	1.80
Flexible Funding – Flexible funding used to fill gaps or acquire additional resources to further systems integration; e.g. existence of a VA and/or community agency fund used for contingencies, emergencies, or to purchase services not usually available for clients.	1.43
Use of Special Waivers - Waiving requirements for funding, eligibility or service delivery to reduce barriers to service, eliminate duplication of services, or promote access to comprehensive services; e.g. VA providing services to clients typically ineligible for certain services (e.g. dental) or community agencies waiving entry requirements to allow clients access to services.	1.47
System Integration Coordinator Position - A specific staff position focused on systems integration activities such as identifying agencies, staffing interagency meetings, and assisting with joint proposal development.	1.87

3. VA/Community Integration

Integration Scale: 1 (low) to 5 (high)	**Site Mean Score (non-VA respondents only)**
VA Accessibility: In general, how accessible do you feel VA services are to homeless veterans in the community?	3.75
VA Service Coordination: Rate the ability of the VA to coordinate clinical services for homeless veterans with your agency.	3.32